# SERVICE REQUEST FORM

TO: INDIANA DEPARTMENT OF INSURANCE
AGENT LICENSING DIVISION
311 WEST WASHINGTON, SUITE 300
INDIANAPOLIS, IN 46204-2787

FROM: _____
Name of Individual or Agency

_____
Mailing Address (Street, P.O. Box, etc.)

_____
City State Zip

_____
Social Security or FEIN Number

**OPTIONS (You may choose more than one)**

| | | | |
|---|---|---|---|
| 1. Change of Residence Address and/or Phone Number | ☐ | 5. Request Letter(s) of Clearance | ☐ |
| 2. Change of address | ☐ | 6. Request Letters(s) of Certification AGENCIES ONLY | ☐ |
| 3. Correct Social Security | ☐ | 7. Request Duplicate License(s | ☐ |
| 4. Change of Business Address and/or Phone Number | ☐ | | |

**NOTE: THE AGENT MUST SIGN THE BACK OF THIS FORM WHERE SHOWN**

**1. ☐ CHANGE OF RESIDENT ADDRESS AND/OR PHONE NUMBER**

Note: State law requires you to notify the Department of a change of address or name within thirty (30) days of the change. Failure to do so will result in a $100.00 penalty, revocation, suspension, or other disciplinary action. If moving from one state to another a certification letter must be attached.

| PRIOR ADDRESS | NEW ADDRESS |
|---|---|
| Street Address Required | Street Address Required |
| | |
| P.O. Box (If Applicable) | P.O. Box (If Applicable) |
| | |
| City State Zip | City State Zip |
| | |
| Phone Number | Phone Number |

**2. ☐ CHANGE OF NAME**

Note: Attach copy of the change (legal documentation).

Name as currently in our record (Last First, Middle) New Name to appear in our records (Last, First, Middle)

**3. ☐ CORRECT SOCIAL SECURITY NUMBER TO:**

Note: You must attach photocopies of at least 2 forms of identification confirming the number you provide below.

☐☐☐-☐☐-☐☐☐☐

**Social Security Number or FEIN** _____

**Agent's or Agency's Name** _____

**4. ☐ CHANGE OF BUSINESS ADDRESS AND/OR PHONE NUMBER**

Note: State law requires you to notify the Department of a change of business address within thirty (30) days of the change. Failure to do so will result in a $100.00 penalty, revocation, suspension, or other disciplinary action.

| PRIOR ADDRESS | NEW ADDRESS |
|---|---|
| | |
| Street Address Required | Street Address Required |
| | |
| P.O. Box (If Applicable) | P.O. Box (If Applicable) |
| | |
| City State Zip | City State Zip |
| Phone Number | Phone Number |

**5. ☐ REQUEST LETTER(S) OF CLEARANCE**

Note: You must return original license(s) to the Department before a Letter of Clearance will be issued. Please enclose a stamped self-addressed envelope of sufficient size to hold the material requested.

I have moved form Indiana to the State of _____. Please cancel all my existing Indiana resident insurance licenses and send me a Letter of Clearance.

**6. ☐ REQUEST LETTER(S) OF CERTIFICATION AGENCIES ONLY How many Copies? _____**

Note: Please enclose a stamped self-addressed envelope of sufficient size to hold the material requested.

**Providers must obtain letters of certification by logging onto www.sircon.com**

**7. ☐ REQUEST DUPLICATE LICENSE(S) ($10.00 FEE REQUIRED)**

| License Type | Reason for Request |
|---|---|
| | |
| | |
| | |

Note: the fee for a duplicate license is $10.00 (personal check, cashiers check or money order). Do NOT send cash. Requests for duplicate license(s) will not be processed unless a fee is received.

**8. ☐ ASSUMED BUSINESS NAME** _____

*__Must Notify the Department Before Using__

_____ _____

Signature of Agent or Officer/Principal of Agency Date

**Renewal Notice:** The department mails a renewal invoice to the producer's resident address on file. If for some reason the producer does not receive a renewal invoice, it is still the producer's responsibility to renew the license. Invoices are mailed to the producer approximately sixty (60) days before the license is due to expire. Contact the Department for a new invoice if an invoice is not received thirty (30) days prior to the license expiration date.